A

ZULHASNIMAR HASAN BASRI & ANOR v. DR KUPPU VELUMANI P & ORS

FEDERAL COURT, PUTRAJAYA
MD RAUS SHARIF PCA
ZAINUN ALI FCJ
B ABU SAMAH NORDIN FCJ
RAMLY ALI FCJ
BALIA YUSOF WAHI FCJ
[CIVIL APPEAL NO: 02(F)-10-02-2015(W)]
25 JULY 2017

C

TORT: *Negligence – Medical negligence – Distinction to be made between diagnosis and treatment and duty to advise of risks for standard of care in medical negligence cases – Case related to matters of diagnosis and treatment – Applicable test – Whether Bolam test or Rogers v. Whitaker test – Whether test in Rogers v. Whitaker as followed in Foo Fio Na restricted only to duty to advise risks*
D *associated with any proposed treatment – Whether extended to diagnosis or treatment – Whether Bolam test applies to standard of care for diagnosis or treatment – Whether Bolam test subject to qualifications in case of Bolitho – Whether medical practitioner has final say as to whether there was negligence*

E

The first appellant, upon presenting herself at the third respondent hospital ('hospital') complaining of abdominal pain, was attended to by a staff nurse and was subsequently admitted into the hospital. She was given medications, as ordered by the first respondent, to lessen her pain. Several hours later, the first appellant suddenly collapsed as the result of severe bleeding. Her blood pressure could not be recorded. A 'Code Blue' alarm for emergency was
F sounded. The first appellant was resuscitated in the ward and was rushed to the operation theatre ('OT') for an emergency caesarean section ('CS') conducted by the first respondent. This was successful and the second appellant was delivered alive. A hysterectomy to remove the first appellant's uterus was performed subsequently with the assistance of the second
G respondent upon discovering that the first appellant had a ruptured blood vessel at the placenta. It was in the course of the emergency hysterectomy that the first and second respondents discovered the blood vessels at the fundus (top) of the first appellant's uterus had ruptured and hence, the sudden acute bleeding and collapse of the first appellant in the ward. The collapse
H had resulted in a sudden and significant loss of oxygen to the second appellant, as a result of which she suffered severe birth asphyxia causing the second appellant now to be suffering from cerebral injury. The appellants' case against the respondents in their claim for medical negligence were: (i) the first appellant was in labour shortly after admission and if CS to
I deliver the second appellant had been performed without delay, the second appellant would not have suffered her present disability; (ii) the first respondent and nursing staff were negligent in failing to diagnose that the first appellant was in labour and instead of carrying out an emergency procedure, CS drugs were given to her to lessen her pains; (iii) the first respondent

should have foreseen that the first appellant might suffer a uterine rupture if CS was delayed given the fact that the first respondent had delivered her first baby by CS when it was discovered she had a condition called cephalo-pelvic disproportion; and (iv) when the first appellant collapsed, the first respondent failed to resuscitate or adequately resuscitate her and the second respondent failed to assist the first respondent to resuscitate the first appellant when the 'Code Blue' alarm was sounded. The High Court found that the appellants failed to prove, on a balance of probabilities, that the first and second respondents had breached their duty and standard of care to them. Consequently, the hospital was found not to be vicariously liable. The appellants' claims were thus dismissed. The Court of Appeal affirmed the decision of the High Court. Leave to appeal was granted by this court on two questions of laws, *inter alia*: (i) whether the *Bolam* test or the test in the Australian case of *Rogers v. Whitaker* in regard to the standard of care in medical negligence should apply, following conflicting decisions of the Court of Appeal in Malaysia and legislative changes in Australia, including the re-introduction of a modified *Bolam* test; and (ii) whether in negligence, a hospital authority may, by reason of a 'non-delegable duty of care', be directly liable for 'organisational and system failures' as decided by the Supreme Court of England in *Woodland v. Essex County Council*.

Held (dismissing appeal)
Per Md Raus Sharif PCA (delivering the judgment of the court):

(1) The approach of the *Bolam* test practically meant that while the law imposed a duty of care, the standard of care owed by a doctor to a patient is left to the medical fraternity *ie*, the 'practice accepted as proper by a responsible body of medical men skilled in that particular art'. In other words, the medical practitioners have the final say whether there was negligence and not the courts. The *Bolam* test as formulated was wide enough to encompass all aspects of medical practice. It made no distinction between diagnosis, treatment or the duty to advise of the risk. (paras 26 & 27)

(2) The majority in *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* ('*Sidaway*') rejected any change to the *Bolam* test and reiterated the applicability of *Bolam* test to the duty to advise of risks. However, there was a strong dissenting view by Lord Scarman who called for a different test to be applied in respect of a doctor's duty to advise of risks. While accepting that the *Bolam* test may continue to apply to diagnosis and treatment, Lord Scarman was of the view that there was a duty on the part of doctors to advise or warn of the risks. (paras 32 & 33)

(3) The High Court of Australia decided differently in *Rogers v. Whitaker* wherein it removed the test which looked to what respectable medical practitioners would do in the circumstances (*Bolam* test) and substituted it with the legal test of materiality. Thus, it is the court

(rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment by applying the materiality test. The court would no longer look to what respectable members of the medical profession would do as being the yardstick to govern the standard of care expected in respect of the duty to advice. Clearly, *Rogers v. Whitaker* departed from the *Bolam* test on the issue of a doctor's duty to provide information or advice to the patient. However, the departure did not affect the standard of care in respect of the duty to diagnose or the duty to treat. In fact, *Rogers v. Whitaker* made a specific distinction between treatment and diagnosis on the one hand and advice of risks on the other – emphasising that the latter had nothing to do with medical expertise, but was predicated on 'the paramount consideration that a person is entitled to make his own decisions about his life'. (paras 40 & 41)

(4) The House of Lords in *Bolitho v. City & Hackney Health Authority* ('*Bolitho*') qualified the *Bolam* test that, if the body of medical opinion does not withstand logical analysis, the court may hold that it is not reasonable or responsible and may then depart from it. In effect, *Bolitho* retained the *Bolam* test for all purposes in respect of medical negligence, but made it subject to the condition that for the expert opinion to be acceptable to the courts, it must be capable of withstanding logical analysis. (para 44)

(5) In Malaysia, the *Bolam* test was the applicable law in the area of medical negligence until the decision of the Federal Court in *Foo Fio Na v. Dr Soo Fook Mun & Anor* ('*Foo Fio Na*'). In *Foo Fio Na*, the court referred to the High Court of Australia in *Naxakis v. West General Hospital* ('*Naxakis*') which extended the principle of *Rogers v. Whitaker* in relation to the duty to advise to the realm of diagnosis and treatment. However, *Foo Fio Na* did not adopt the principle in *Naxakis* or extend the principle in *Rogers v. Whitaker* to the realm of diagnosis or treatment. Hence, the decision in *Foo Fio Na* must necessarily be limited only to the duty to advise of risks. In coming to the said decision, the court had made specific reference to *Rogers v. Whitaker*, acknowledging it to be the applicable test. However, *Foo Fio Na* dealt only with a medical practitioner's duty to advise of risks associated with a proposed treatment. It did not deal with the standard of care expected in respect of either diagnosis or treatment. (paras 49, 56 & 57)

(6) In respect of the standard of care in medical negligence cases, a distinction must be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other. This is because diagnosis and treatment are purely in the realm of medicine and in the field of medicine, there are genuine differences of professional opinion in respect of diagnosis and treatment. Although as a discipline,

medicine involves specific knowledge, its practice, however, often does not admit to scientific precision. It is not always the case that there is a definite answer one way or the other. In fact, medical experts do genuinely and frequently differ in opinion on diagnosis and treatment. (para 94)

(7) In the present case, based on the two cardiotocographys ('CTGs') that were carried out, the first appellant was found not to be in labour by the doctors, including Dr Ong, the appellants' expert. Hence, the trial judge had not erred in concluding that the first appellant was not in labour. The trial judge's findings of fact on this issue were reasonably explained and supported by evidence. Whether the first appellant was in labour or not and whether the CS had been done and whether the first appellant's collapse could have been avoided, were clearly matters relating to diagnosis and treatment. The applicable test would be the *Bolam* test, which meant that the medical practitioners had the final say as to whether there was negligence on the part of the first respondent. Based on the evidence and even by applying the *Bolam* test, the appellants failed to prove that the first respondent, or for that matter, the second respondent were negligent in diagnosing and treating the appellants. (paras 67 & 71)

(8) The criticisms that the courts below failed to decide that following the first appellant's collapse, whether from a uterine rupture or otherwise, there was a further delay in performing the emergency CS, were totally misplaced. The trial judge had appreciated all the contentions raised by the appellants and having perused the evidence in great detail, found that there was no delay in performing the emergency CS. The Court of Appeal, having scrutinised the evidence, was of the view that the conclusion arrived at by the trial judge on the issue did not warrant its intervention. This court also agreed with the Court of Appeal that there was no reason to interfere in the trial judge's findings of fact that the first appellant was in fact resuscitated and there was no delay in doing so (paras 72-75 & 80)

(9) The specific allegations against the first and second respondents for their alleged breach of duty of care owed to the first and second appellants were not proven. The only complaint against the second respondent was his failure to assist the first respondent in resuscitating the first appellant after the 'Code Blue' alarm was sounded. According to evidence, the second respondent came out of his room to respond to the emergency call but on seeing the first appellant being attended to by the first respondent, he walked back to his room. But thereafter, he assisted the first respondent at the OT for the emergency CS on the first appellant. Accordingly, the appellants' appeals against the first and second respondents were dismissed. As the first and second respondents were not negligent, the issue of the hospital being vicariously liable did not arise. (paras 81 & 82)

(10) There was no real evidence that the hospital failed to comply with reg. 20(4)(a) of the Private Hospitals Regulations 1973 which provides that there must be two nurses on duty at the maternity ward. Evidence showed that there would be three or four nurses on duty in one shift. It was also clear from the evidence that the first appellant was regularly monitored while she was under the care of the hospital and all her complaints were conveyed to the first respondent. The nurses had also complied with the instructions given to them by the first respondent in the management of the first appellant. Further, there was no evidence to show that the time taken to move the first appellant from the maternity ward to the OT was too long. The CS was performed within 30 minutes which was acceptable and within the recognised time frame. (paras 86, 87, 89 & 90)

(11) In the circumstances, in answering the first question, it was held that the test in *Rogers v. Whitaker* and followed by *Foo Fio Na* in regard to the standard of care in medical negligence is restricted to only to the duty to advise the risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applies, subject to qualifications in *Bolitho*. In light of this, there was no necessity to answer the second question. (paras 97 & 98)

Bahasa Malaysia *Headnotes*

Perayu pertama, setibanya di hospital responden ketiga ('hospital') mengadu sakit di bahagian abdomen, dirawat oleh jururawat am dan kemudian didaftar masuk ke hospital itu. Dia diberikan ubat, seperti yang diarahkan responden pertama, untuk mengurangkan kesakitannya. Beberapa jam kemudian, perayu pertama tiba-tiba tidak sedarkan diri akibat pendarahan yang banyak. Tekanan darahnya tidak boleh direkodkan. Loceng kod biru bagi kecemasan dibunyikan. Perayu pertama dipulihkan di dalam wad dan dihantar segera ke bilik pembedahan bagi pembedahan caesarean ('CS') kecemasan dilakukan oleh responden pertama. Pembedahan tersebut berjaya dan perayu kedua selamat dilahirkan. Histerektomi untuk membuang rahim perayu pertama dilakukan kemudiannya dengan bantuan responden kedua apabila didapati bahawa perayu pertama mengalami salur darah pecah pada plasenta. Hanya semasa histerektomi kecemasan responden pertama dan kedua mengetahui bahawa saluran darah pada bahagian fundus rahim perayu pertama pecah mengakibatkan pendarahan mendadak tiba-tiba hinggakan perayu pertama tidak sedarkan diri di dalam wad. Keadaan tersebut mengakibatkan perayu kedua kehilangan oksigen secara tiba-tiba dan dengan banyak dan dengan itu mengalami asfiksia kelahiran teruk menyebabkan perayu kedua kini mengalami kecederaan serebrum. Kes perayu-perayu terhadap responden-responden dalam tuntutan bagi kecuaian perubatan adalah: (i) perayu

pertama mengalami kesakitan pelahiran sejurus selepas dimasukkan ke hospital dan jika pembedahan untuk melahirkan perayu kedua dilakukan tanpa kelengahan, perayu kedua tidak akan mengalami kecacatan yang dialaminya sekarang; (ii) responden pertama dan kakitangan jururawat cuai kerana gagal mendiagnosis perayu pertama sedang mengalami kesakitan pelahiran dan tidak menjalankan prosedur kecemasan, sebaliknya, ubat CS diberikan kepadanya untuk mengurangkan kesakitannya; (iii) responden pertama sepatutnya meramal bahawa perayu pertama akan mengalami pecah rahim jika pembedahan CS lewat dilakukan memandangkan responden pertama adalah doktor semasa perayu pertama melahirkan anak pertamanya melalui pembedahan CS apabila didapati dia mengalami keadaan dipanggil 'cephalo-pelvic disproportion'; dan (iv) apabila perayu pertama tidak sedarkan diri, responden pertama gagal memulihkan perayu pertama atau gagal memulihkannya dengan secukupnya dan responden kedua gagal membantu responden pertama memulihkan perayu pertama apabila loceng kod biru dibunyikan. Mahkamah Tinggi mendapati perayu-perayu gagal membuktikan, atas imbangan kebarangkalian, responden pertama dan kedua melanggar kewajipan dan standard berjaga-jaga terhadap mereka. Dengan itu, hospital didapati tidak bertanggungan secara vikarius. Tuntutan perayu-perayu, dengan itu, ditolak. Mahkamah Rayuan mengesahkan keputusan Mahkamah Tinggi. Kebenaran merayu diberikan mahkamah ini atas dua persoalan undang-undang, antara lain: (i) sama ada ujian *Bolam* atau ujian dalam kes Australia, *Rogers v. Whitaker* berkaitan standard berjaga-jaga dalam kecuaian perubatan terpakai, berikutan keputusan-keputusan Mahkamah Rayuan yang bertentangan dan perubahan perundangan di Australia, termasuk pengenalan semula ujian *Bolam* terubah suai di sana; dan (ii) sama ada dalam kecuaian, pihak berkuasa hospital boleh, atas alasan 'kewajipan berjaga-jaga tidak boleh diwakilkan', bertanggungan secara langsung bagi 'kegagalan organisasi dan sistem' seperti diputuskan oleh Mahkamah Agung England dalam *Woodland v. Essex County Council*.

Diputuskan (menolak rayuan)

Oleh Md Raus Sharif PMR (menyampaikan penghakiman mahkamah):

(1) Pendekatan dalam ujian *Bolam* secara praktikalnya bermaksud bahawa walaupun undang-undang mengenakan kewajipan berjaga-jaga, standard berjaga-jaga oleh doktor terhadap pesakit diletakkan pada bidang perubatan iaitu 'amalan yang diterima sebagai wajar oleh kumpulan pakar perubatan bertanggungjawab yang berkemahiran dalam bidang tertentu itu'. Dalam erti kata lain, pengamal perubatan dan bukan mahkamah yang berhak memberi kata putus sama ada terdapat kecuaian. Ujian *Bolam* seperti yang dibentuk adalah cukup luas untuk merangkumi kesemua aspek amalan perubatan. Ujian ini tidak membezakan antara diagnosis, rawatan atau kewajipan untuk menasihati berkaitan dengan risiko.

(2) Majoriti dalam kes *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* ('*Sidaway*') menolak apa-apa perubahan pada ujian *Bolam* dan mengulangi pemakaian ujian *Bolam* bagi kewajipan menasihati tentang risiko. Walau bagaimanapun, pendapat menentang Lord Scarman menyarankan ujian berbeza digunakan bagi kewajipan doktor menasihati tentang risiko. Walaupun beliau menerima bahawa ujian *Bolam* boleh terus digunakan untuk diagnosis dan rawatan, Lord Scarman berpendapat bahawa doktor-doktor berkewajipan menasihati atau memberi amaran tentang risiko.

(3) Mahkamah Tinggi Australia memutuskan dengan berbeza dalam *Rogers v. Whitaker* dan menolak ujian yang mana pengamal perubatan bereputasi akan lakukan dalam keadaan tersebut (ujian *Bolam*) dan menggantikannya dengan ujian undang-undang kematanan. Oleh itu, mahkamah (dan bukan kumpulan pengamal perubatan bereputasi) yang akan memutuskan sama ada pesakit dinasihatkan dengan sewajarnya berkaitan risiko yang terlibat dengan rawatan yang dicadangkan dengan menggunakan ujian kematanan. Mahkamah juga tidak akan melihat pada apa yang akan dibuat oleh ahli-ahli profesion perubatan bereputasi sebagai pengukur nilai untuk menentukan standard berjaga-jaga yang diharapkan berkaitan kewajipan menasihati. Jelas *Rogers v. Whitaker* menyimpang daripada ujian *Bolam* berkaitan isu kewajipan doktor memberi maklumat atau menasihati pesakit. Walau bagaimanapun, penyimpangan tersebut tidak menjejaskan standard berjaga-jaga berkaitan kewajipan mendiagnosis atau merawat. Hakikatnya, *Rogers v. Whitaker* membezakan secara spesifik antara rawatan dan diagnosis dan nasihat terhadap risiko – menekankan bahawa nasihat terhadap risiko tiada kaitan dengan kepakaran perubatan, tetapi berdasarkan pada 'pertimbangan utama bahawa seseorang berhak membuat keputusannya sendiri berkenaan kehidupannya.'

(4) House of Lords dalam *Bolitho v. City & Hackney Health Authority* ('*Bolitho*') membataskan ujian *Bolam* bahawa, jika pendapat badan perubatan tidak dapat bertahan analisis logik, mahkamah boleh memutuskan bahawa badan perubatan tidak munasabah atau bertanggungjawab dan mungkin kemudiannya menyimpang daripadanya. Kesannya, *Bolitho* mengekalkan ujian *Bolam* bagi kesemua tujuan berkaitan kecuaian perubatan, tetapi mengehadkannya dengan syarat bahawa bagi pendapat pakar diterima mahkamah, pendapat pakar tersebut mesti boleh bertahan analisis logik.

(5) Di Malaysia, ujian *Bolam* adalah undang-undang yang diguna pakai dalam bidang kecuaian perubatan sehingga keputusan Mahkamah Persekutuan dalam kes *Foo Fio Na v. Dr Soo Fook Mun & Anor* ('*Foo Fio Na*'). Dalam kes *Foo Fio Na*, mahkamah merujuk pada kes Mahkamah Tinggi Australia dalam *Naxakis v. West General Hospital*

('*Naxakis*') yang melanjutkan prinsip *Rogers v. Whitaker* berkaitan kewajipan menasihati dalam bidang diagnosis dan rawatan. Walau bagaimanapun, *Foo Fio Na* tidak mengguna pakai prinsip *Naxakis* atau melanjutkan prinsip *Rogers v. Whitaker* kepada bidang diagnosis dan rawatan. Oleh itu, keputusan *Foo Fio Na* sepatutnya dihadkan hanya untuk kewajipan menasihati mengenai risiko. Dalam mencapai keputusan tersebut, mahkamah merujuk pada kes *Rogers v. Whitaker* secara spesifik, mengakui ini adalah ujian yang diguna pakai. Walau bagaimanapun, *Foo Fio Na* hanya menangani kewajipan pengamal perubatan untuk menasihati tentang risiko yang terlibat dalam rawatan yang dicadangkan. Ini tidak berkaitan dengan standard berjaga-jaga yang diperlukan berkaitan diagnosis dan rawatan.

(6) Bagi standard berjaga-jaga dalam kes-kes kecuaian perubatan, satu perbezaan mesti dibuat antara diagnosis dan rawatan dalam satu bahagian dan kewajipan menasihati mengenai risiko dalam bahagian satu lagi. Ini adalah kerana diagnosis dan rawatan adalah dalam bidang perubatan dan dalam bidang perubatan, terdapat perbezaan ketara mengenai pendapat profesional berkaitan dengan diagnosis dan rawatan. Walaupun sebagai satu bidang, perubatan melibatkan pengetahuan spesifik, tetapi, secara praktikalnya, ini tidak selalu menerima ketepatan saintifik. Kebiasaannya, tiada kes di mana terdapat satu jawapan tepat. Hakikatnya, pakar-pakar perubatan selalu berbeza pendapat secara jujur berkaitan dengan diagnosis dan rawatan.

(7) Dalam kes ini, berdasarkan dua kardiotokografi ('CTG') yang dilakukan, perayu pertama didapati belum mengalami sakit pelahiran oleh doktor-doktor, termasuk Dr Ong, pakar perayu-perayu. Dengan itu, hakim bicara tidak terkhilaf dalam kesimpulannya bahawa perayu pertama belum sakit pelahiran. Dapatan hakim bicara dalam isu ini dijelaskan dengan secukupnya dan disokong oleh keterangan. Sama ada perayu pertama sakit pelahiran atau tidak, dan sama ada pembedahan CS telah dilakukan dan sama ada keadaan di mana perayu pertama tidak sedarkan diri boleh dielakkan, adalah jelas perkara berkaitan dengan diagnosis dan rawatan. Ujian yang diguna pakai adalah ujian *Bolam*, yang bermaksud pengamal perubatan mempunyai hak membuat kata putus sama ada wujud kecuaian pada pihak responden pertama. Berdasarkan keterangan, dan malahan mengguna pakai ujian *Bolam*, perayu-perayu gagal membuktikan bahawa responden pertama atau kedua cuai dalam diagnosis dan rawatan perayu-perayu.

(8) Kritikan bahawa mahkamah-mahkamah bawahan gagal memutuskan bahawa, berikutan keadaan perayu pertama tidak sedarkan diri, sama ada daripada kepecahan rahim atau sebaliknya, terdapat kelewatan lanjut dalam menjalankan pembedahan CS kecemasan, adalah salah tanggapan sama sekali. Hakim bicara telah mempertimbangkan

kesemua hujahan yang dibangkitkan perayu-perayu dan setelah menilai keterangan dengan mendalam, mendapati tiada kelewatan dalam melakukan pembedahan CS kecemasan. Mahkamah Rayuan, selepas menilai keterangan, berpendapat keputusan yang dicapai hakim bicara atas isu tersebut tidak mewajarkan campur tangan. Mahkamah ini juga bersetuju dengan Mahkamah Rayuan bahawa tiada alasan untuk campur tangan dalam dapatan fakta hakim bicara bahawa perayu pertama sebenarnya telah dipulihkan dan tiada kelewatan dalam berbuat demikian.

(9) Dakwaan spesifik terhadap responden pertama dan kedua bagi pelanggaran kewajipan berjaga-jaga pada perayu pertama dan kedua tidak dibuktikan. Satu-satunya aduan terhadap responden kedua adalah kegagalannya membantu responden pertama dalam memulihkan perayu pertama selepas loceng kod biru dibunyikan. Menurut keterangan, responden kedua keluar dari biliknya untuk menjawab panggilan kecemasan tetapi apabila melihat perayu pertama sedang dirawat oleh responden pertama, dia kembali ke biliknya. Tetapi kemudian, dia membantu responden pertama dalam OT bagi pembedahan CS kecemasan atas perayu pertama. Dengan itu, rayuan perayu-perayu terhadap responden pertama dan kedua ditolak. Oleh sebab responden pertama dan kedua tidak cuai, isu bahawa hospital bertanggungan secara vikarius tidak berbangkit.

(10) Tiada keterangan jelas bahawa hospital gagal mematuhi peraturan 20(4)(a) Peraturan-Peraturan Hospital Persendirian 1973 yang memperuntukkan bahawa mesti ada dua jururawat bertugas di wad bersalin. Keterangan menunjukkan bahawa ada tiga atau empat orang jururawat bertugas dalam satu syif. Juga jelas daripada keterangan bahawa perayu pertama sentiasa diperhatikan semasa dia dalam jagaan hospital dan kesemua aduannya disampaikan kepada responden pertama. Jururawat-jururawat juga mematuhi kesemua arahan yang diberi kepada mereka oleh responden pertama dalam menguruskan perayu pertama. Selanjutnya, tiada keterangan menunjukkan bahawa masa yang lama diambil untuk memindahkan perayu pertama dari wad bersalin ke OT. Pembedahan yang dijalankan dalam tempoh masa 30 minit boleh diterima dan adalah dalam jangka masa yang diiktiraf.

(11) Dalam keadaan tersebut, menjawab soalan pertama, diputuskan bahawa ujian *Rogers v. Whitaker*, dan diikuti dalam *Foo Fio Na* berkaitan standard berjaga-jaga dalam kecuaian perubatan, terhad pada hanya kewajipan menasihati tentang risiko yang berkait dengan apa-apa rawatan yang dicadangkan dan tidak berlanjut pada diagnosis dan rawatan. Berkaitan dengan standard berjaga-jaga bagi diagnosis dan rawatan, ujian *Bolam* masih diguna pakai, tertakluk pada pengehadan dalam *Bolitho*. Dengan itu, tiada keperluan menjawab soalan kedua.

Case(s) referred to:

Abdul Razak Datuk Abu Samah v. Raja Badrul Hisham Raja Zezeman Shah & Ors [2013] 3 CLJ 1130 HC ***(refd)***

Azizah Abdul Manan & Ors v. Dr Norlelawati Ab Latip & Ors [2014] 2 CLJ 44 HC ***(refd)***

Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 ***(refd)***

Bolitho v. City & Hackney Health Authority [1997] 3 WLR 1151 ***(refd)***

Canterbury v. Spence 464 F 2d 722 ***(refd)***

Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors [2008] 1 LNS 411 HC ***(refd)***

Chin Keow v. Government of the Federation of Malaya & Anor [1964] 1 LNS 22 HC ***(refd)***

Chin Keow v. Government of & Anor [1967] 1 LNS 25 PC ***(refd)***

Dato' Dr V Thuraisingam & Anor v. Sanmarkan Ganapathy & Anor [2015] 8 CLJ 248 CA ***(refd)***

Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor [2007] 5 CLJ 38 CA ***(refd)***

Dr B Pillay v. Loh Hon Fui & Ors [2011] 1 LNS 1260 HC ***(refd)***

Dr Chai Hoon Seong v. Wong Meng Heong [2009] 10 CLJ 118 HC ***(refd)***

Dr Gun Suk Chyn & Ors v. Kartar Kaur Jageer Singh & Anor [2014] 1 CLJ 838 CA ***(refd)***

Dr Noor Aini Hj Sa'ari v. Sa-Art Sae Lee & Anor [2016] 2 CLJ 23 CA ***(refd)***

Edward Wong Finance Co Ltd v. Johnson Stokes & Master [1984] AC 296 ***(refd)***

Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***

Gleneagles Hospital (KL) Sdn Bhd v. Chung Chu Yin & Ors And Another Appeal [2013] 8 CLJ 449 CA ***(refd)***

Gurmit Kaur Jaswant Singh v. Tung Shin Hospital & Anor [2013] 1 CLJ 699 HC ***(refd)***

Hariesh Kumar Muthragi lwn. Kerajaan Malaysia & Yang Lain [2011] 1 LNS 1058 HC ***(refd)***

Hasan Datolah v. Kerajaan Malaysia [2010] 5 CLJ 764 CA ***(refd)***

Hucks v. Cole [1993] 4 Med LR 393 ***(refd)***

James Kenneth Eng Siew Goh v. Lee King Ong [2009] 10 CLJ 154 HC ***(refd)***

Ku Jia Shiuen & Anor v. Kerajaan Malaysia & Ors [2013] 9 CLJ 489 HC ***(refd)***

Lai Ping v. Dr Lim Tye Ling & Ors [2014] 10 CLJ 442 HC ***(refd)***

Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor [2008] 3 CLJ 76 HC ***(refd)***

Lim Zi Hong v. Pengarah Hospital Selayang & Ors [2013] 10 CLJ 412 HC ***(refd)***

Mathew Scott Oakley & Ors v. Dr George Varughese Anor [2010] 10 CLJ 322 HC ***(refd)***

Mohd Shafie Abdul Samat v. Penguasa Perubatan dan Satu Lagi [2011] 9 MLJ 254 ***(refd)***

Montgomery v. Lanarkshire Health Board [2015] 2 WLR 768 ***(refd)***

Muhammad Yassien Zuliskandar & Ors v. Kerajaan Malaysia [2010] MLJU 2163 ***(refd)***

Natahlie Nordberg (An Infant Suing Through Her Mother And Next Friend, Elizabeth Chin Yew Kim) v. Dr Quah Thong Sai & Anor And Another Case [2015] 10 CLJ 509 HC ***(refd)***

Naxakis v. West General Hospital [1999] 197 CLR 269 ***(refd)***

Norazleen Mohammed Mustaffa v. Dr Omar Md Isa & Anor [2015] 4 CLJ 474 CA ***(refd)***

Norizan Abd Rahman v. Dr Arthur Samuel [2013] 4 CLJ 275 HC ***(refd)***

Pearce and Another v. United Bristol Healthcare NHS Trust [1998] 48 BMLR 118 ***(refd)***

R Neelameghan Ramasamy & Anor v. Noor Faizan Saaidin & Ors [2012] 1 LNS 1041 HC ***(refd)***

Reibln v. Huges 114 DLR (3d) 1 SC ***(refd)***

Roger v. Whitaker [1993] 4 Med LR 79 ***(refd)***

Rogers v. Maree Lynette Whitaker (1992) 175 CLR 479 ***(refd)***

Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 ***(refd)***

A *Woodland v. Essex County Council [2014] 1 All ER 482* ***(refd)***
Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors [2013] 10 CLJ 862 HC ***(refd)***
Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors [2016] 4 CLJ 416 CA ***(refd)***

B **Legislation referred to:**
Evidence Act 1950, ss. 46, 51
Private Hospitals Regulations 1973, reg. 20(4)(a)
Rules of the Federal Court 1995, rr. 47(4), 57(1)

For the appellant - PS Ranjan, Manmohan S Dhillon, Karthi Kanthabalan & Ramakrishna Tharini; M/s PS Ranjan & Co
C *For the 1st & 2nd respondents - Darryl SC Goon, Maidzuara Mohammed & Charlaine Chin; M/s Raja Darryl & Loh*
For the 3rd respondent - M Anad Krishnan & S Anpalagar; M/s Anad & Noraini
Amicus Curie - Cecil Abraham, JJ Chan, Sunil Abraham, Fazleeza Azli & Ellaine Alexander

D *[Editor's note: For the Court of Appeal judgment, please see Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors [2016] 4 CLJ 416 (affirmed).]*

Reported by S Barathi

JUDGMENT

E **Md Raus Sharif PCA:**

Introduction

[1] This is an appeal against the decision of the Court of Appeal given on 8 May 2014 which affirmed the decision of the High Court dismissing the appellants' claims against the respondents.

F

[2] In this appeal, the first appellant, Zulhasminar binte Hasan Basri is the mother of the second appellant. The second appellant, Khairina Puteri binte Sariman is an infant who is suing by her father and next friend, Sariman bin Saad.

G **[3]** The first respondent, Dr Kuppu Velumani and the second respondent, Dr Marlik Abu at the material time were consultant obstetricians and gynecologists with a practice at Ampang Puteri Specialist Hospital which is owned and operated by the third respondent, a private hospital providing public healthcare services (the hospital).

H **[4]** The appellants' claims against the respondents were for medical negligence. The High Court found that the appellants failed to prove on a balance of probabilities that the first and second respondents had breached their duty and standard of care to them. Consequently, the third respondent was found not to be vicariously liable, as liability had not been attributed to
I the first and second respondents.

[5] Leave to appeal was granted by this court on 29 January 2015 on two questions of law which read:

Question 1

Whether the *Bolam* test or the test in the Australian case of *Rogers v. Whitaker* [1993] 4 Med LR 79 in regard to the standard of care in medical negligence should apply, following conflicting decisions of the Court of Appeal in Malaysia and legislative changes in Australia, including the re-introduction there of a modified *Bolam* test.

Question 2

Whether in negligence a hospital authority may, by reason of a "non-delegable duty of care", be directly liable for "organizational and system failures" as decided by the Supreme Court of England in *Woodland v. Essex County Council* [2014] 1 All ER 482.

Material Facts

[6] The first appellant was pregnant and had chosen the first respondent to be her obstetrician and gynecologist since she was the doctor who had delivered her first baby by caesarian section (CS). The first appellant had seen the first respondent at least four times during the course of her pregnancy.

[7] In the early morning of 3 May 2002 at 36 weeks of her pregnancy, the first appellant presented herself at the hospital complaining of abdominal pain. She was attended to by a staff nurse and after having performed various checks on her, she was admitted into the hospital. The first appellant's pulse was high at 108 and her blood pressure was 122/68. After the medications of pethedine and phernegan, ordered by the first respondent were given, the first appellant's pulse came down to 80 and her blood pressure was 110/70. Later, in the morning the first respondent visited her in the ward.

[8] Sometime between 10.50am to 11am that morning, the first appellant suddenly collapsed as the result of severe bleeding. Her blood pressure could not be recorded. A 'Code Blue' alarm for emergency was sounded. The first appellant was resuscitated in the ward and was rushed to the operation theatre (OT) for an emergency CS conducted by the first respondent. This was successful and the second appellant was delivered alive. A hysterectomy to remove the first appellant's uterus was performed subsequently with the assistance of the second respondent upon discovering that the first appellant had a ruptured blood vessel at the placenta.

[9] It was in the course of the emergency hysterectomy the first and second respondents discovered that the blood vessels at the fundus (top) of the first appellant's uterus had ruptured and hence the sudden acute bleeding and collapse of the first appellant in the ward. The collapse had resulted in a sudden and significant loss of oxygen to the second appellant, as a result of which she suffered severe birth asphyxia causing the second appellant now to be suffering from cerebral injury. Immediately after birth, the management of the second appellant was handed over to the fifth defendant in the initial

claim, the late Dr Haliza Mohamad Shafie. The latter kept the second appellant alive. However, the suit against her was withdrawn when she passed away.

At The High Court

[10] Originally, six parties were sued by the appellants for medical negligence. However, midway through the trial, the claims of the appellants were only against the first, second and the third respondents.

[11] Briefly, the appellants' case against the respondents were: (i) the first appellant was in labour shortly after admission and if CS to deliver the second appellant had been performed without delay, the second appellant would not have suffered her present disability; (ii) the first respondent and nursing staff were negligent in failing to diagnose that the first appellant was in labour and instead of carrying out an emergency procedure, CS drugs were given to her to lessen her pains; (iii) the first respondent should have foreseen that the first appellant might suffer a uterine rupture if CS was delayed given the fact that the first respondent had delivered her first baby by CS when it was discovered she had a condition called cephalo-pelvic disproportion and (iv) when the first appellant collapsed, the first respondent failed to resuscitate or adequately resuscitate her and the second respondent failed to assist the first respondent to resuscitate the first appellant when the 'Code Blue' alarm was sounded.

[12] As against the third respondent (hospital), the appellants claimed direct negligence on the part of the nurses, a system failure, and vicarious liability for the failure of the nurses and doctors.

[13] The first and second respondents contended that the bleeding suffered by the first appellant was not caused by a uterine rupture but due to the rupture of the blood vessels on her uterus. It was the first and second respondents' case that the first appellant had a one-in-a million condition: known as placenta percreta, where the placenta, which normally adhered to the inner lining of the uterus grew through the wall of the organ. In the first appellant's case, the placenta had not only grown through but had come out the top of her uterus making that condition virtually undetectable unless a surgical examination was done.

[14] Further, the first and second respondents denied that they were responsible for any delay in attending to the first appellant and contended that the first appellant was closely monitored since the time of her admission and did not show signs of being in labour at any time. The first and second respondents further contended that given the first appellant's obstetric history, an elective CS would have been done if she was at 38 weeks gestation but not when the gestation was only 36 weeks and that, too, when she was not in labour. The first and second respondents contended that the need for emergency CS only arose when the first appellant lost consciousness, that

within 15 minutes of her collapse the first appellant was in the OT to have the emergency procedure done, and that the second appellant was delivered within 30 minutes of first appellant's collapse.

[15] The hospital denied any direct negligence on its part and on the part of the nurses and doctors, that there was any systemic failure. The hospital alternatively contended that it cannot be vicariously liable in the circumstances of this case.

[16] The High Court, after a lengthy trial which stretched over 50 days, involving the testimony of 12 medical doctors and four others, dismissed the appellants' claims against the respondents. In dismissing the claims, the High Court held that:

(i) The appellants failed to prove on a balance of probabilities that the first and second respondents had breached their duty and standard of care to them. The appellants failed to show that the first appellant was in labour so as to have merited an earlier CS being performed on her. They also failed to show that there was uterine rupture which was foreseeable and preventable by the first respondent.

(ii) Sufficient evidence was established to show that the first appellant suffered from an abnormal presentation of the uterus of the rarest kind known as placenta percreta. Such abnormal presentation was not detectable either during routine antenatal check-up or by way of sophisticated machine except by surgery. No liability was therefore attributed to the first and second respondents. Consequently, the hospital was not vicariously liable.

(iii) There was no evidence to suggest that the uterine rupture had caused the bleeding. It transpired that the rupture of the uterine vein at the outer wall of the uterus had caused the massive bleedings. The first respondent could not have been expected to have detected the placenta percreta in the uterus or to have foreseen the events that subsequently happened.

(iv) The nursing records showed that when the first appellant collapsed in the ward, the first respondent was there and the 'Code Blue' alarm was sounded. From the time of her collapse to the time she arrived at the OT, in all, it took 15 minutes, which, going by the evidence of the expert witnesses, was a reasonable time-frame. The delivery of the second appellant within 30 minutes from the time of the collapse was also acceptable; in fact, it was an internationally accepted standard. The circumstances did not show that there was any delay in the management of the first appellant by the first respondent, as the reason for the unfortunate outcome in the birth of the second appellant.

(v) There was no breach of duty or negligence on the first respondent's part in her handling of the first appellant after her collapse. The evidence showed that the first respondent did resuscitate the first appellant upon her collapse before sending her to the OT. The first respondent's failure to record the procedure could not nullify that fact.

(vi) Based on all the evidence, the first appellant was not at any time in labour. There was no regular uterine contractions and dilation of her cervix to conclusively show that she was in labour. The appellants' contention that a CS should have been performed before her collapse was baseless as it was hindsight wisdom. Since the first appellant was not in labour, there was no reason for an emergency CS to have been performed earlier. It was when she collapsed that the need for an emergency CS arose.

(See *Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors* [2013] 10 CLJ 862).

At The Court Of Appeal

[17] The appellants' appeal to the Court of Appeal was heard over three days, and the Court of Appeal by a unanimous decision, affirmed the judgment of the trial judge. Before the Court of Appeal, the main issues raised by the appellants were:

(i) whether the trial judge had misdirected herself on the issue of 'vicarious liability' on the part of the hospital. It was alleged that the trial judge failed to address the issue of direct evidence of negligence on the part of the staff employed by the hospital and the failure of the hospital's organisational system;

(ii) whether there was a delay on the part of the first respondent in attending to and managing the first appellant;

(iii) whether the first appellant was in labour upon admission;

(iv) whether the probable cause of collapse of the first appellant was due to uterine rupture or rupture of the vessels on the uterus resulting from a condition called placenta percreta; and

(v) whether there was insufficient judicial appreciation of the evidence by the trial judge.

[18] In dismissing the appeal, the Court of Appeal held that:

(i) the trial judge had painstakingly analysed the evidence of facts as to every action taken by the nurses and doctors including the first and second respondents, as specialists in attending to the appellants;

(ii) the trial judge had correctly concluded that the hospital was not negligent though she did not specifically address the claim against the hospital, based on direct evidence;

(iii) the evidence and the facts of this case did not support the appellants' contention that the first and second respondents were negligent. The trial judge had meticulously considered and examined the evidence relied on by the appellants to support the contention that the first appellant could have collapsed at 10.45am or even earlier at 10.40am as suggested by the appellants, and had come to a finding that the collapse occurred at about 11am. Therefore, if the second appellant was delivered at 11.25am it was within the acceptable 30 minute window. Thus, on the evidence and finding of facts by the trial judge, it could not be said that there was delay by the first and second respondents in attending to the first appellant;

(iv) the trial judge was right in concluding that the first appellant was not in labour at the time of admission or at any time after that, up to the time when the first appellant collapsed in the ward;

(v) the evidence showed that there was no uterine rupture. When the first appellant was taken to the OT after the collapse, the first and second respondents testified that the uterus was intact with the placenta. It was discovered that it was the vessels on the outer surface of the uterus, at the fundus, that ruptured (placenta percreta). The trial judge observed that the evidence of the first and second respondents, the expert Dr Rahman, the pathologist Dr Patel, as well as the appellants' own expert Dr Ong was consistent in that placenta percreta was a rare condition and could not be detected even with advanced imaging techniques. The second respondent in his evidence said that placenta percreta at the fundus as in this case was even rarer because it did not give any symptom. This view was shared by Dr Ong, the appellants' own expert. The rarity of the placenta percreta condition was confirmed by Dr Patel when he testified that in his 20 years of practice as a pathologist that he had only seen one such case which was the present case; and

(vi) there was nothing wrong in the trial judges preference of one expert opinion over the other if she could reasonably explain the preference which was done in the instant case. The court could not find fault with the manner the trial judge had judicially considered all the evidence in this case in arriving at her findings of fact. The appellants had failed to establish, on a balance of probabilities, a case in negligence against the respondents.

(See *Zulhasnimar Hassan Basri & Anor v. Dr Kuppu Velumani P & Ors* [2016] 4 CLJ 416).

At The Federal Court

[19] As stated earlier, two questions of law were posed before this court. We will first deal with question 1.

Question 1

Whether the *Bolam* test or the test in the Australian case of *Roger v. Whitaker* [1993] 4 Med LR 79, in regard to the standard of care in medical negligence should apply, following conflicting decisions of the Court of Appeal in Malaysia and legislative changes in Australia including the re-introduction there of a modified *Bolam* test.

Development Of The *Bolam* Test

[20] The *Bolam* test was propounded by McNair J in *Bolam v. Friern Management Committee* [1957] 2 All ER 118. The test was pertaining to the duty and standard of care of a medical practitioner *vis a vis* a patient. In that case, the plaintiff, John Hector Bolam, consented to undergo electroconvulsive therapy but was not warned of the risk of fracture. In the course of the treatment, both the plaintiff's hip joints were dislocated with fracture of the pelvis on each side.

[21] In claiming damages for his injuries against the management of the hospital, the plaintiff contended that the hospital was vicariously liable in permitting the doctor to negligently administer electroconvulsive therapy, without administering a relaxant drug prior to the treatment or providing some form of manual restraint and failing to warn him of the risk involved before the treatment was given.

[22] The medical evidence at the trial showed that the doctors held divergent views on the desirability of using relaxant drugs and restraining the patient's body by manual control and also on the question of warning a patient of the risk of electroconvulsive therapy. The other medical evidence of importance was that the risk of fracture was 1 in 10,000.

[23] In the course of summing up to the jury, McNair J made the following remarks on the standard of proof in a medical negligence suit:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

[24] On the duty and standard of care of a doctor *vis a vis* a patient, McNair J made this pronouncement:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[25] The jury, relying on the direction of McNair J and the divergent medical evidence, found the hospital was not negligent. The direction of McNair J to the jury is now called the famous *Bolam* test.

[26] The approach of the *Bolam* test practically meant that while the law imposed a duty of care, the standard of care owed by a doctor to a patient is left to the medical fraternity ie, the "practice accepted as proper by a responsible body of medical men skilled in that particular art". In other words, the medical practitioners had the final say whether there was negligence and not the courts.

[27] The *Bolam* test as formulated was wide enough to encompass all aspects of medical practice. It made no distinction between diagnosis, treatment or the duty to advise of the risk. Instead, the test offered a single all-encompassing and comprehensive test to be applied to medical practitioners in the discharge of every aspect of the duty of care they owe to their patients.

[28] In England, the *Bolam* test withstood the test of time until almost 30 years later when an attempt was made to introduce a different test, specifically in respect of a medical practitioner's duty to advise as opposed to the duty to diagnose and treat. This happened in *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871.

[29] In *Sidaway*, the patient had a recurrent pain in her neck, right shoulder and arms. She underwent an operation by a senior neuro-surgeon. The operation was such that even if it were performed with proper care and skill, it still had an inherent material risk of damage to the spinal column and the nerve roots. The risk was assessed at between 1% to 2%. The patient underwent the proposed surgery and in consequence became severely disabled. The patient alleged that the surgeon did not advise her of this risk.

[30] The trial judge found that while the surgeon did tell the patient of the possibility of disturbing the nerve root and the consequences, he did not refer to the danger of damage to the spinal cord. However, the trial judge found that in doing so, the surgeon was following a practice which in 1974 would have been accepted as proper by a responsible body of skilled and experienced neurosurgeons and applying the *Bolam* test, the patient's action was dismissed.

[31] Before the House of Lords, the issue was specifically on the question of advise ie, a doctor's duty to advise his patient. Lord Diplock put it in the following words:

> What your Lordships have been asked to do – and it is within our power to do so – is to substitute a new and different rule for that part only of the well established *Bolam* test as comprises a doctor's duty to advise and warn the patient of risks of something going wrong in the surgical or other treatment that he is recommending.
>
> The juristic basis of the proposed substitution which originates in certain state court jurisdictions of the United States of America and has found some favour in modified form by the Supreme Court of Canada, appears to me, with great respect, to be contrary to English law.

[32] After much analysis and despite the North American cases of *Canterbury v. Spence* 464 F 2d 722 CA and *Reibln v. Huges* 114 DLR (3d) 1 SC, the majority of the Law Lords rejected any change to the *Bolam* test and reiterated the applicability of *Bolam* test to the duty to advise of risks. Lord Diplock in his concluding judgment said:

> To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The *Bolam* test should be applied.

[33] Thus, *Sidaway* rejected any new test that might have been applicable solely in respect of a doctor's duty to advise in preference for a singular test ie, the *Bolam* test. However, there was a strong dissenting view by Lord Scarman who called for a different test to be applied in respect of a doctor's duty to advise of risks. While accepting that the *Bolam* test may continue to apply to diagnosis and treatment, Lord Scarman was of the view that there was a duty on the part of doctors to advise or warn of the risks. His Lordship said it in these words:

> Responsible medical judgment may, indeed, provide the law with an acceptable standard in determining whether a doctor in diagnosing or treatment was complied with his duty. But is it right that medical judgment should determine whether there exists a duty to warn of risk and its scope? It would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognises a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes.

[34] Lord Scarman's point was that the patient's right to make his own decision may be seen as a basic human right is protected by the common law. In His Lordship's view, the failure to warn a patient of the risks inherent in the operation which is recommended, constitutes a failure to respect the patient's right to make his own decision. Thus, His Lordship saw no reason in principle why, if the risk materialises and injury or damage was caused, the law should not recognise it and enforce it as a right of the patient to be compensated by way of damages.

[35] Lord Scarman concluded by stating:

> My conclusion as to the law is therefore this. To the extent that I have indicated, I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing: and especially so, if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a

> reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.

[36] However, on the facts and applying the test he suggested, Lord Scarman came to the same conclusion as did the majority, that the appeal should be dismissed. But the significance of *Sidaway* was the majority view as expressed by Lord Diplock, that the law imposes a single comprehensive duty covering the ways in which a doctor exercises his skill and judgment in respect of a patient. This duty is all encompassing. It covers all aspects of a doctor's duty to the patient ie, treatment, diagnosis and advise and is not to be dissected into separate components.

[37] The Australian High Court in *Rogers v. Maree Lynette Whitaker* (1992) 175 CLR 479 decided differently. In that case the plaintiff, Mrs Whitaker had only one good eye. She was advised that an operation on the bad eye would improve its appearance and probably restore significant sight. She underwent the operation resulting in her losing sight completely of one good eye, due to a condition known as sympathetic ophthalmia. The defendant failed to advise the plaintiff of this risk of sympathetic ophthalmia which upon evidence, only occurs once in approximately 14,000 cases.

[38] The High Court of Australia took the view that the factors to determine whether there was a breach of duty vary according to whether it involves diagnosis, treatment or provision of information or advise. It held that:

> The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty. However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors …
>
> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended.
>
> Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been

given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment.

[39] In conclusion, the Australian High Court held:

The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.

[40] It is clear from the above that the High Court of Australia had removed the test which looked to what a respectable medical practitioner would do in the circumstances (*Bolam* test) and substituted this test with the legal test of materiality. Thus, it is now the court (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment by applying the materiality test. The court would no longer look to what respectable members of the medical profession would do as being the yardstick to govern the standard of care expected in respect of the duty to advise.

[41] Clearly, the High Court of Australia departed from the *Bolam* test on the issue of a doctor's duty to provide information or advise to the patient. However, the departure did not affect the standard of care in respect of the duty to diagnose or the duty to treat. In fact, the High Court of Australia made a specific distinction between treatment and diagnosis on the one hand and advise of risks on the other – emphasising that the latter had nothing to do with medical expertise, but was predicated on "the paramount consideration that a person is entitled to make his own decisions about his life".

[42] The effect of the decision in *Rogers v. Whitaker* in rejecting the *Bolam* test was to take the final say as to whether there is a duty to advise, and the scope of that duty out of the hands of medical practitioners. In place of the medical view, the court propounded a materiality test which was to be applied and decided by the courts. In Australia, the departure from the *Bolam* test was complete when, in the field of treatment, the principle in *Rogers v. Whitaker* was subsequently extended and applied by the High Court of Australia (see *Naxakis v. West General Hospital* [1999] 197 CLR 269).

[43] With changes elsewhere, the courts in England were also shifting their positions. The House of Lords in *Bolitho v. City & Hackney Health Authority* [1997] 3 WLR 1151, qualified the *Bolam* test in a manner which provided a slender opportunity for the court to depart from *Bolam*. The qualification was this, in the words of Lord Browne – Wilkinson after referring to the cases of *Hucks v. Cole* [1993] 4 Med LR 393, and *Edward Wong Finance Co Ltd v. Johnson Stokes & Master* [1984] AC 296 where His Lordship said:

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence.

[44] In *Bolitho*, the qualification to *Bolam* test was that, if the body of medical opinion does not withstand logical analysis, the court may hold that it is not reasonable or responsible and may then depart from it. In effect, *Bolitho* retained the *Bolam* test for all purposes in respect of medical negligence, but made it subject to the condition that for the expert opinion to be acceptable to the courts, it must be capable of withstanding logical analysis.

[45] In the meantime, the law continues to develop in England. Despite the majority decision in *Sidaway*, which endorsed the continued application of *Bolam* test and also the decision in *Bolitho*, the English Court of Appeal in *Pearce and Another v. United Bristol Healthcare NHS Trust* [1998] 48 BMLR 118 decided differently. Lord Woolf MR after referring to the decisions in *Bolam*, *Sidaway* and *Bolitho* stated that:

> In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seem to me to be the law, as indicated in the cases to which I have just referred, that if there is a significant risk which would affect the judgment of a reasonable patient,

A then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for himself or herself as to what course he or she should adopt.

[46] The above expression of law which clearly relates to the responsibility B of a doctor to inform the patient and seems to echo the views of Lord Scarman in *Sidaway*, the minority view, rather than the majority and seems somewhat inconsistent with the decision in *Bolam* and *Bolitho*. This was expressed by the Law Lords in *Montgomery v. Lanarkshire Health Board* [2015] 2 WLR 768 where Lord Kerr of Tonaghmore and Lord Reed JJSC said:

C 69. In more recent case law, the English courts, have generally treated Lord Woolf MR's statement in the *Pearce* case [1999] PIQR P53 as the standard formulation of the duty to disclose information to patients, although some unease has on occasion been expressed about the difficulty of reconciling that approach with the speeches of Lord Diplock and Lord Bridge in *Sidaway's* case [1985] AC 871: D see for example *Birch v. University College London Hospital NHS Foundation Trust* [2008] 104 BMLR 168.

[47] It can be seen that the Court of Appeal in *Pearce* had begun moving away from the *Bolam* test in relation to duty to advise although it could be said that the doctrine of *stare decisis* was not properly observed.

E

The *Bolam* Test In Malaysia

[48] In Malaysia, the *Bolam* test was first applied in 1964 by Ong J in *Chin Keow v. Government of the Federation of Malaya & Anor* [1964] 1 LNS 22; [1964] 30 MLJ 322. Ong J's judgment was overturned by the Federal Court F but was subsequently upheld by the Privy Council in *Chin Keow v. Government of Malaysia & Anor* [1967] 1 LNS 25; [1967] 2 MLJ 45 (by then the Federation of Malaya had become Malaysia). In the Privy Council, Sir Hugh Wooding stated:

It was not in dispute that before prescribing or authorising the injection G to be given Dr. Devadason did not inquire into the deceased's medical history. On the contrary, he frankly admitted this himself. So the sole question which Ong J. had to determine was whether any duty lay on the doctor to make such inquiry. For this purpose he adopted the test, in their lordships' opinion quite rightly, which was propounded by McNair J in *Bolam v. Friern Hospital Management Committee* …

H

[49] Since then, the *Bolam* test was the applicable law in the area of medical negligence until the decision of this court in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229; [2007] 1 MLJ 593. In that case, the appellant became totally paralysed after undergoing surgery for neck injuries I (dislocated vertebrae) at the second respondent's hospital. The appellant alleged that the paralysis was caused by the treatment procedure adopted by the first respondent, an orthopedic surgeon at the hospital, and in the circumstances sued the respondents for medical negligence. The High Court Judge found for the appellant, ruling: (i) that, whilst the appellant might have

consented to the operation, she was not told of the risk of paralysis that might arise from the operation; and (ii) that the first respondent was negligent in that, in seeking to correct the dislocation, he had put in place a wire loop which had compressed the spinal cord and caused the paralysis.

[50] In deliberating on the issue of the scope of a doctor's duty of care, the trial judge in *Foo Fio Na* declined to apply the *Bolam* test. However, the Court of Appeal, whilst steering clear of commenting on the *Bolam* principle, allowed the appeal on the ground that there was no evidence to establish that it was the surgery performed by the first respondent that caused the paralysis. Leave to appeal to this court was sought and obtained on a point of law which reads:

> Whether the *Bolam* Test as enunciated in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118, in the area of medical negligence should apply in relation to all aspects of medical negligence.

[51] This court answered the question in the negative. In doing so, this court adopted the test set out in the Australian case of *Rogers v. Whitaker* and held:

> [39] … we are of the opinion that the *Bolam* Test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.
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> …
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> [78] … there is a need for members of the medical profession to stand up to the wrongdoings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis, we are of the view that the *Rogers v. Whitaker* test would be a more appropriate and a viable test of this millennium then *[sic]* the *Bolam* Test. …

[52] Since the decision of this court in *Foo Fio Na*, two inconsistent lines of our courts' decisions on the principles to be applied in medical negligence have arisen. On one hand, there were decisions of the High Court and the Court of Appeal where it was held that the *Bolam* test no longer applies and that it is now for the court to decide whether there has been a breach of the standard of care by a medical practitioner. According to this line of decisions, because of what was decided by this court in *Foo Fio Na*, the standard of care expected of a medical practitioner is now to be governed by the test in *Rogers v. Whitaker*. (See *Norazleen Mohammed Mustaffa v. Dr Omar Md Isa & Anor* [2015] 4 CLJ 474; *Natahlie Nordberg (An Infant Suing Through Her Mother And Next Friend, Elizabeth Chin Yew Kim) v. Dr Quah Thong Sai*

& Anor And Another Case [2015] 10 CLJ 509; *Azizah Abdul Manan & Ors v. Dr Norlelawati Ab Latip & Ors* [2014] 2 CLJ 44; *Ku Jia Shiuen & Anor v. Kerajaan Malaysia & Ors* [2013] 9 CLJ 489; [2013] 4 MLJ 108; *Norizan Abd Rahman v. Dr Arthur Samuel* [2013] 4 CLJ 275; [2013] 9 MLJ 385; *Abdul Razak Datuk Abu Samah v. Raja Badrul Hisham Raja Zezeman Shah & Ors* [2013] 3 CLJ 1130; [2013] 10 MLJ 34; *Lim Zi Hong v. Pengarah Hospital Selayang & Ors* [2013] 10 CLJ 412; *Gurmit Kaur Jaswant Singh v. Tung Shin Hospital & Anor* [2013] 1 CLJ 699; [2012] 4 MLJ 260; *R Neelameghan Ramasamy & Anor v. Noor Faizan Saaidin & Ors* [2012] 1 LNS 1041; *Hariesh Kumar Muthragi lwn. Kerajaan Malaysia & Yang Lain* [2011] 1 LNS 1058; *Dr B Pillay v. Loh Hon Fui & Ors* [2011] 1 LNS 1260; *Hasan Datolah v. Kerajaan Malaysia* [2010] 5 CLJ 764; [2010] 2 MLJ 646; *Dr Chai Hoon Seong v. Wong Meng Heong* [2009] 10 CLJ 118; [2010] 8 MLJ 104; *Muhammad Yassien Zuliskandar & Ors v. Kerajaan Malaysia* [2010] MLJU 2163; *Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors* [2008] 1 LNS 411; [2009] 7 MLJ 261; *Mathew Scott Oakley & Ors v. Dr George Varughese Anor* [2010] 10 CLJ 322; [2009] MLJU 1429; and *Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor* [2007] 5 CLJ 38; [2007] 5 MLJ 552).

[53] However, there are decisions of the High Court and Court of Appeal which emphasised that the test in *Foo Fio Na* and *Rogers v. Whitaker* relates only to a medical practitioner's duty to advise or provide information to a patient and this does not apply to the standard of care that is expected from a medical practitioner in respect of the duty to diagnose and to treat. (See *Dr Noor Aini Hj Sa'ari v. Sa-Art Sae Lee & Anor* [2016] 2 CLJ 23; *Dato' Dr V Thuraisingam & Anor v. Sanmarkan Ganapathy & Anor* [2015] 8 CLJ 248; *Lai Ping v. Dr Lim Tye Ling & Ors* [2014] 10 CLJ 442; [2015] 8 MLJ 62; *Dr Gun Suk Chyn & Ors v. Kartar Kaur Jageer Singh & Anor* [2014] 1 CLJ 838; *Gleneagles Hospital (KL) Sdn Bhd v. Chung Chu Yin & Ors and Another Appeal* [2013] 8 CLJ 449; [2013] 4 MLJ 785; *Mohd Shafie bin Abdul Samat v. Penguasa Perubatan dan Satu Lagi* [2011] 9 MLJ 254; *James Kenneth Eng Siew Goh v. Lee King Ong* [2009] 10 CLJ 154; [2009] 4 MLJ 396; and *Lechemanavasagar S Karuppiah v. Dr Thomas Yau Pak Chenk & Anor* [2008] 3 CLJ 76; [2008] 1 MLJ 115).

Answer To Question 1

[54] Question 1 raises the issue as to whether the *Bolam* test or the test in the Australian case of *Rogers v. Whitaker* with regard to the standard of care in medical negligence should apply.

[55] Before answering the question, it should be noted that this court in *Foo Fio Na* made specific reference to the test in *Rogers v. Whitaker*. This is significant because *Rogers v. Whitaker* was entirely concerned with the duty to advise and no more. That entire case concerns a medical practitioner's duty to advise, drawing the distinction between the duty to advise and the duty to diagnose or treat. On the facts of the case, this court in *Foo Fio Na* held that:

[30] It cannot be disputed that the 1st Respondent was under a duty to advice the Appellant on the course of treatment to be undertaken and the risks involved and the issue is whether there has been a breach of that duty. …

[33] But the issue here is not so much on the consents given for the two operations but on the risks involved and whether the Appellant was warned of such risks. She had testified that had she been warned of the risks involved, she would not have readily agreed to undergo the first operation.

[34] There was conflicting evidence on this and the trial judge made the following findings when dealing with the Appellant's first expressed consent.

> It would also be concluded that at the time when that consent was signed both Defendants did not know whether the Plaintiff really needed the operation. As such, I am of the view that it would not be possible for the Second Defendant to explain the procedure and the risks of the operation when the consent in the above-stated form was given or signed. For that reason, I believe the Plaintiff when she said that the Second Defendant told her that the first operation (open reduction) which took place on 19 July 1982 was a minor operation to correct the little problem of the neck that she was suffering. In other words, she was not told of the risk of paralysis coming from that operation.

[56] It should also be noted that in *Foo Fio Na* although the decision of the High Court of Australia in *Naxakis v. West General Hospital (supra)* was referred to, it was not relied upon for the *ratio decidendi* of this court's decision. As stated earlier, the case of *Naxakis* was where the High Court of Australia extended the principle of *Rogers v. Whitaker* in relation to the duty to advise to the realm of diagnosis and treatment. In short, this court in *Foo Fio Na* did not adopt the principle in *Naxakis* or extend the principle in *Rogers v. Whitaker* to the realm of diagnosis or treatment.

[57] Based on the above, we are of the view that the decision of this court in *Foo Fio Na* must necessarily be limited only to the duty to advise of risks, this is because in coming to the said decision, it had made specific reference to *Rogers v. Whitaker*, acknowledging it to be the applicable test. This court in *Foo Fio Na* however dealt only with a medical practitioner's duty to advise of risks associated with a proposed treatment. It did not deal with the standard of care expected in respect of either diagnosis or treatment.

[58] In the present case, learned counsel for the appellants submitted that whichever test is to be applied in this case, negligence should have been found against the respondents. It was submitted that the *Bolam* test as qualified in *Bolitho*, or the test in *Rogers v. Whitaker* as adopted by this court in *Foo Fio Na* were the applicable test. According to learned counsel for the appellants, either test must be applied, read with ss. 46 and 51 of the Evidence Act 1950.

[59] Learned counsel for the first and second respondents on the other hand submitted that whichever way question 1 is answered, it would be of no relevance to the outcome of this case as the allegations of fact against the first and second respondents were never proven. It was pointed out that whether it was the *Bolam* test or *Foo Fio Na* and *Rogers v. Whitaker* which was to be applied was not even an issue raised at the trial, since none of the particulars of negligence were proven. Accordingly, the question of the applicable test for negligence never arose.

[60] Learned counsel for the hospital (third respondent) submitted that despite a number of witnesses called by the appellants, the trial judge found that no real evidence was led to show that there was any direct evidence of negligence on the part of the hospital, nor was there any evidence to show that there was negligence in the way nursing care was provided. It was submitted that the trial judge had examined the facts and the manner in which the first appellant was treated from the time she was admitted to the hospital till the operation and clearly found that there was no negligent conduct on the part of the hospital or its servants.

[61] We found that the trial judge was fully aware of the applicable test which is to be applied for cases of negligence against doctors. She was fully aware of the *Bolam* test, the dissenting view of Lord Scarman in *Sidaway* which was later developed in *Rogers v. Whitaker* which was followed by this court in *Foo Fio Na*. She was also aware of the decision of the House of Lord in *Bolitho* and other authorities on the subject.

[62] Guided by the said authorities, the trial judge came to the conclusion that the appellants had failed to prove on a balance of probabilities to establish that the first and second respondents were in breach of their duty of care, when the appellants failed to show on evidence that the first appellant was in labour to merit an earlier CS to be performed on her. The trial judge also found that the appellants had failed to prove that there was uterine rupture which was foreseeable and preventable by the first respondent in view of the first appellant's history with regard to her first pregnancy. On the other hand, sufficient evidence was established to show that the first appellant was suffering from the abnormal presentation of the uterus which is the rarest kind known as placenta percreta. According to the trial judge, such abnormal presentation was rare and cannot be detected by any sophisticated machine except by way of surgery. At the Court of Appeal, the issue with regard to the test to be applied in determining the standard of care owed by the respondents to the appellants was not even canvassed before the court.

[63] Thus, it was pointed out by learned counsel for the first and second respondents that question 1 now posed before this court was never an issue raised or argued in the courts below. It was further submitted that it has never been the contention of the first and second respondents that the principles of

law in *Foo Fio Na* applied to diagnosis and treatment or that the *Bolam* test no longer applied to a medical practitioner's duty and standard of care in respect of diagnosis or treatment.

[64] It was further pointed out that in the appellants' memorandum of appeal were grounds with numerous objections involving findings of fact by the trial judge in respect of which the Court of Appeal found that there was no error. None of these grounds has anything to do with question 1 posed by the appellants. This according to learned counsel is contrary to r. 47(4) and r. 57(1) of the Rules of the Federal Court 1995 which states as follows:

> 47(4) The hearing of the appeal shall be confined to matters, issues or question in respect which leave to appeal has been granted.
>
> 57(1) Subject to rule 47(4) of these rules, the appellant shall prepare a memorandum of appeal setting forth concisely and under distinct heads, without argument or narrative, the grounds of objection to the decision appealed against and specifying the points of law or fact which are alleged to have been wrongly decided, such grounds to be numbered consecutively.

[65] We are aware of the above provisions. The grounds of objection permissible in a memorandum of appeal must necessarily refer to matters, issues or questions in respect of which leave to appeal was granted. However, in the present case, we have allowed learned counsel for the appellants to extensively canvass the facts and evidence adduced in assessing the facts and evidence canvassed, it is inevitable that we have to decide on the standard of care of a medical practitioner since there are conflicting decisions made on the issue. We hope our decision in this case will finally resolve this conflict.

[66] In this appeal, one of the main issues raised by learned counsel for the appellants was the failure of the courts below to decide that the first appellant was in labour. It was the appellants' case that the first appellant was in labour at the material time and if a CS had been done, the collapse could have been avoided. In dealing with this issue, the trial judge held:

> [105] The contention of learned counsel that CS should have been performed at 10 am in my view is hindsight wisdom. We are here more concern with foresight of a reasonable medical practitioner in the circumstances presented. This is the principle stated by Lord Scarman in *Maynard v. West Midlands RHA* [1985] 1 All ER 635 when he said "It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper". We now know, after the event that the first plaintiff collapsed at around 11 am. It can now from hindsight perspective be viewed that a CS upon collapsed is a delay. However since the first plaintiff did not present herself in a state of labour, there was no reason that an emergency CS would have to be performed

A anytime earlier. In view of that, a reasonable medical practitioner would not perform a CS in absence of labour. Thus the criticism that an earlier CS should have been done is clearly baseless.

[67] We have gone through the evidence and the contemporaneous records and consonant with the Court of Appeal, we found that the trial judge had B not erred in concluding that the first appellant was not in labour. In this case, there were two cardiotocographys (CTGs) that were carried out. The first CTG was done on admission and the first appellant was found not to be in labour. The doctors, including Dr Ong (the appellants' expert) agreed that the first appellant was not in labour at that time.

C **[68]** The second CTG was carried at about 8.50am to 9.10am. The first respondent's clinical notes recorded "mild irritated like contractions". The first respondent in her evidence testified that the first appellant was not in labour and gave her reason ie, that there was no progressive cervical dilation and no regular uterine contractions of sufficiently high intensity in the second D CTG. Her evidence was consistent with the evidence of Dr Raman (DW7), the first and second respondents' expert, who testified that the first appellant was not in labour based on the contemporaneous records. DW7's evidence was that labour can only be diagnosed if there are regular uterine contractions with progressive dilation of the cervix of more than 3-4cm.

E **[69]** The divergent of opinion came from the appellants' expert, Dr Ong who in his written opinion stated that the first appellant was "in pre-term labour". He also stated that the CTG from 8.50am onwards showed regular uterine contractions, ie, the patient was in pre-term labour. He further stated that "in normal obstetric practice, to suppress established pre-term labour, F one would use either bricanyl drip or a ventolin drip, rather than use an oral drug. Dr Mani's decision to prescribe oral bricanyl (tablets) is not appropriate". In Dr Ong's opinion, uterine contractions alone are sufficient to conclude that a patient was in labour.

[70] Faced with the divergence of opinion, the trial judge preferred G Dr Raman's view which she noted was supported by medical text presented. On the other hand, she found Dr Ong's testimony on this point to be confusing and that he prevaricated. The Court of Appeal in dealing with the issue of whether the first appellant was in labour concluded as follows:

H [47] Having scrutinised the evidence and the reasoning by the learned Judge we are of the view that her conclusion on the issue does not warrant our intervention.

… We see nothing wrong in the learned Judge's preference of one expert over the other if she can reasonably explain the preference (which in this instant we think the learned Judge had done).

I **[71]** We are of the same view. The trial judge was entitled to make such findings of fact. And we found that her findings of fact on this issue were reasonably explained and supported by evidence. It is our judgment that

whether the first appellant was in labour or not and whether the CS had been done and whether the appellant's collapse could have been avoided, are clearly matters relating to diagnosis and treatment. The applicable test would be the *Bolam* test. It simply means that the medical practitioners had the final say as to whether there was negligence on the part of the first respondent. In this regard, there was a divergence of views among the medical practitioners who gave evidence in this case. Thus, based on the evidence and even by applying the *Bolam* test, the appellants had failed to prove that the first or for that matter the second respondent were negligent in diagnosing and treating the appellants.

[72] Another contentious issue raised on behalf of the appellants was that the courts below had failed to decide that, following the first appellant's collapse, whether from a uterine rupture or otherwise, there was a further delay in performing the emergency CS. And the courts below had failed to decide that there was no or insufficient resuscitation of the first appellant before she was brought into the OT for the emergency CS. It was the contention of the appellants that the trial judge had erred in failing to take sufficient or any account of the evidence or the issues of the alleged delay to undertake an emergency CS.

[73] With respect, we disagree. From the grounds of judgment, the trial judge appreciated the contentions, considered all the material evidence and made finding of facts based on the evidence. The trial judge dealt with it in the following manner:

> [93] The plaintiff mounted a case of delay in the management of the first plaintiff by Dr Kuppu Velumani. It is the plaintiffs' case that CS should have been done on the first plaintiff at 10 am the plaintiffs relied on the evidence of Dr Marlik and argued that 15 minutes time taken, to bring patient from the ward to the OT is a delay. The plaintiffs contended that Dr Kuppu Velumani gave various inconsistent records of time on the events. The plaintiffs argued that if time is approximation it should be so stated in the report or notes. The plaintiffs contended she should have attended and came up to see the first plaintiff right at 10.30 am when she received the first phone call from the nurse.
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> [94] The events preceding the collapse of the first plaintiff as disclosed in the course of trial are these. Dr Kuppu Velumani said she received a call from the nurse that the first plaintiff vomited. In the nursing report at p. 328 of bundle B the notes by the nurse states that at 10.30 am there is an entry "T/O from LBR" which means the patient was transferred from labour room, corresponding with the instruction of Dr Kuppu Velumani's earlier visit around 10 am. Upon receiving report that the first plaintiff was vomiting, Dr Kuppu Velumani instructed for the first plaintiff to be given intravenous dextrose and maxolon to stop vomiting.

A [95] The plaintiffs' case is that Dr Kuppu Velumani delayed in responding to the telephone calls made by nurses. Nursing record (exh. 1 p. 19) shows that the nurses made two telephone calls, one at 10.30 am and another at 10.50 am. In her record, Dr Kuppu Velumani noted in her notes that she came to the first plaintiff at 11 am. Encik PS Ranjan contended that this shows the delay by Dr
B Kuppu Velumani in attending to the first plaintiff. By that alleged delay, relying on the expert opinion of Dr Ong that the first plaintiff was in labour a CS should have been performed on the first plaintiff at least at 10.30 am. He submitted that if that was done the whole episode could have been avoided.

C [96] When these facts and evidence are juxtaposed what is clear is that, during the period between 10.30 am to 11 am telephone calls were made to the first defendant by the nurse. According to the nurse's records there were two telephone calls made. The first was at 10.30 am. In this telephone call, the nurse informed the Dr Kuppu Velumani that the first plaintiff was in pain and vomited. Dr Kuppu
D Velumani ordered intravenous drip of 5% dextrose and maxolon (anti-drug for nausea). The drugs were administered as instructed.

[97] Another call was made by the nurse at 10.50 am to inform Dr Kuppu Velumani that the patient was still in pain. She then came to see the plaintiff as shown in the nurse record at 10.55 am. In Dr Kuppu
E Velumani's report, it was noted to be at 11 am. The first defendant was severely cross-examined by Encik PS Ranjan on the discrepancies in time between nurse's records and the doctor's record not only on this episode but almost throughout the course of trial whenever such discrepancies arise.

F [98] The explanation by the Dr Kuppu Velumani repeatedly in the course of the trial plus a few other medical witnesses is that "time" recorded in the entries cannot be exact in the circumstances and they are always mere approximations. This is because doctors do not normally jot down time before taking steps in the management of patient. It is not possible in all circumstances that time can be
G accurately recorded because doctors need to attend to emergencies at hand before putting the events on record.

[99] In my view this explanation is acceptable and reasonable. Whilst I agree with learned counsel that records are important to be accurately kept, surely attending to patient is always priority. As records are then put to papers at the end of an episode it is
H acceptable that detailed information may be missed out.

[100] Quite apart from record keeping, in my view, the more important thing to be looked at is whether a proper management of the patient had indeed taken place. This is shown on the result and impact on the patient. Hence, the failure to note or record certain event need
I not necessarily conclude that such treatments are not administered on the patient. The outcome or the result of certain administration or management on the patient would have to be placed importance,

rather than purely relying on the records and account made by nurses or doctors. It is therefore important to keep in view this information in analysing the treatment given by the defendants.

[101] Having appraised with all the relevant evidence, I now come back to the contention of the counsel for the plaintiffs that Dr Kuppu Velumani should have performed the CS on the first plaintiff at 10 am or 10.30 am, relying on the opinion given by Dr Ong. Upon my scrutiny of the opinion of Dr Ong again, and I take note that in para 3 at p. 67 of the report he opined that a CS was to be done because in his view the second CTG tracings shows a regular uterine contractions and the patient was in fact in labour. In fact if the prognosis of labour is solely based on uterine contractions alone and not even regular contractions the first plaintiff can be said to be in labour even as early as 8.50 am. Having agreed with the opinion that labour has not commenced in the first plaintiff the proposition that there should be CS done at 10 am does not hold good.

[102] In my view the alleged delay should be measured from the time the patient collapse (which was recorded at 10.55 am) to the time she was taken to the OT for CS which is recorded to be at 11.15 am. This in the opinion of Dr Raman is well within accepted practice. In the final analysis the fact that the first plaintiff was taken to the OT in less than 30 minutes from her state of collapse is an acceptable practice according to Dr Raman. I am therefore not able to appreciate the suggestion of the counsel for the plaintiffs that the time used to suggest computation of delay must be computed from 10.30 am when the patient complained of pain and vomiting. Even if Dr Kuppu Velumani were to come up to see the patient at 10.30 am in the ward by her own observation she would not have brought the patient for a CS at the time because the first plaintiff was not in labour. It was only when she collapsed at 10.55 am that the need for CS arose.

[74] It can be seen from the above that the trial judge had perused the evidence in great detail and found that there was no delay in performing the emergency CS. The Court of Appeal in dealing with the same issue held:

[45] The learned Judge approached the issue whether a planned CS should have been considered or otherwise by examining the fact whether on admission at any time after that the 1st plaintiff was in labour.

[46] The learned Judge devoted more than 30 paragraphs in her judgment discussing the evidence by both sides on the issue. She had also considered the expert evidence of Dr Ong and Dr Rahman together with the evidence of the 1st defendant. In addition, the learned Judge had also reviewed the medical literature referred or cited to her on the issue of labour at near term or on full term pregnancy.

A [47] Having scrutinised the evidence and the reason by the learned Judge we are of the view that her conclusion on the issue does not warrant our intervention.

[75] Thus, it can be seen that the courts below had dealt extensively on the issue and we have no reason to depart from their findings. The criticism B against the courts below is totally misplaced.

[76] On the issue of resuscitation, the trial judge dealt with it in the following manner:

[106] The plaintiffs asserted that Dr Kuppu Velumani was negligent in the management of the first plaintiff when her records do not show that C she resuscitated the first plaintiff upon her collapse. The allegation is premised on the following:

(i) There was no record made in first defendant's notes that she resuscitated the patient before sending her to the OT.

D (ii) The notation by Dr Arul in the OT notes that he, with the help of Dr Azhar did the initial resuscitation showed that the first plaintiff was resuscitated only in the OT.

(iii) The opinion of Dr Ong that the resuscitation was not done properly because the record showed that the patient was in a decomposed state with hypertension and tachycardia from 10.55 E am to 12 pm (ie. For more than 65 minutes).

[107] Dr Kuppu Velumani in her testimonies said, the first plaintiff was resuscitated immediately in the ward upon her collapse. She admitted that she made no record in her notes, that she resuscitated the first plaintiff. Nevertheless, she maintained that she resuscitated F her upon her collapse. In support of her claim, she pointed out the records in exh. D51 which recorded two units of haemaccel were used in the maternity ward. D51 is a hospital record of pharmacy items used by the patient in the ward. It was explained by both Dr Raman and Dr Kuppu Velumani that haemaccel is a colloid used for resuscitation to prevent hypovolemia due to large loss of blood.

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[109] In the light of all the above evidence I am inclined to accept the defendant's case and her evidence that there was resuscitation in fact done. My reasons are these. First, there is record on the use of haemaccel in the ward shown in exh. D51. Since haemaccel is only used for the purpose of resuscitating a patient and nothing else H it goes to support her case that she used them to resuscitate the first plaintiff. Secondly, Dr Kuppu Velumani's report at B-24 in the first paragraph states that … "At the time the patient's blood pressure and the pulse was not recordable. Resuscitative measures were done at the same time …". Thirdly, it is a fact that the first plaintiff had an unrecordable BP in the ward. Upon arrival at the OT her BP was I recordable and according to Dr Arul's report (at p. B-80), the patient was semi-comatose, with pulse rate of 160/min and systolic blood pressure was 40/mmHg. It was explained by Dr Raman that from an unrecordable state to a recordable state upon arrival at the OT,

it shows that resuscitation must have taken place, otherwise her BP would not read at systolic BP of 40/mmHg, on arrival at OT. The fact that the first plaintiff's BP was recorded at 40mm/Hg from a non recordable state shows that resuscitation measure was undertaken.

[110] There is eye witness of resuscitation taking place. When Dr Marlik responded to code blue call, he rushed to the ward. He saw the intravenous line on the patient. He saw fluids were pushed into the patient in the ward.

[77] Again, the trial judge fully appreciated the appellants' contentions. She had analysed the evidence. She also dealt with the first respondent's alleged inconsistency as to the time the events took place. She made a finding of fact based on the nursing record which showed that the first appellant collapsed at approximately 11am and the second appellant was delivered within 30 minutes of the first appellant's collapse. The trial judge also made a finding that the first respondent was present when the first appellant collapsed. She then concluded:

[149] … what is more than clear based on the testimonies of the witnesses is that when the patient collapsed. Dr Kuppu Velumani was in the ward and Code Blue was sounded. From the time of her collapse to the time she arrived at the OT, in all, it took 15 minutes. Taking into account the resuscitation done, oxygen to be given and the transfer of the 1st Appellant to OT it took 15 minutes. Going by the evidence of the expert witnesses, 15 minutes is indeed a reasonable practice of any hospital.

[78] We are of the view that the trial judge had dealt with the issue thoroughly by identifying the appellant's contentions and analysing the evidence. The trial judge found as a fact that there was resuscitation in the ward and she gave her reasons for her finding, based on the evidence led. We find there was more than ample evidence to support the findings of fact by the trial judge.

[79] In respect of the issue of resuscitation, the Court of Appeal held as follows:

[26] Perusing the written judgment of the learned Judge, we observe that the learned Judge had dealt with the issue of resuscitation at great length and had considered all the evidence. Excerpts from her judgment will show this to be true …

[80] The Court of Appeal did not find any reason to interfere in the trial judge's findings of fact that the first appellant was in fact resuscitated and there was no delay in doing so. We are of the same view.

[81] In conclusion, we find that the specific allegations against the first and second respondents for their alleged breach of duty of care owed to the first and second appellants were not proven. In fact, the only complaint against the second respondent was his failure to assist the first respondent in

resuscitating the first appellant after the 'Code Blue' alarm was sounded. According to evidence, the second respondent came out of his room to respond to the emergency call but on seeing the first appellant being attended to by the first respondent, he walked back to his room. But thereafter, he assisted the first respondent at the OT for the emergency CS on the first appellant.

[82] Accordingly, we dismiss the appellants' appeals against the first and second respondents. As the first and second respondents were not negligent, the issue of the third respondent (hospital) being vicariously liable does not arise in this case.

[83] But that is not the end of the matter. It was contended by learned counsel for the appellants that the Court of Appeal had failed to give sufficient or any weight to the fact that the trial judge had not considered at all the appellants' pleaded and presented case or direct liability on the part of the hospital for the organisational and systemic failure which caused the accident suffered by the appellants. It was also contended that the courts below had failed to give any or sufficient weight to the unchallenged evidence on both sides that there was a failure on the part of the hospital and the nurses employed by it. Further, it was contended that the Court of Appeal had failed to give sufficient or any weight to the fact that the trial judge had mistakenly seen the case against the hospital as one of vicarious liability regarding the acts of the first and second respondents.

[84] Specifically, learned counsel for the appellants contended that the trial judge and the Court of Appeal in deciding that the hospital was not directly liable had failed to consider the following:

(i) failure of the hospital to comply with reg. 20(4)(a) of the Private Hospitals Regulations 1973, so as to have on duty at the maternity ward the required minimum number of nurses and midwives;

(ii) the undisputed evidence that no midwife was present in the ward and the evidence of Dr Rahman (DW7) that midwives are an essential part of the team;

(iii) the evidence of Dr Rahman (DW7) that the management of the case by "the nurses and midwives was sub-standard after 9.50am";

(iv) the evidence of the appellants' obstetric expert Dr Ong (DW3) criticising the management of the case by the nurses;

(v) the evidence of Professor Lim (DW2) that there was "a failure in the alarm system";

(vi) the evidence of Dr Rahman that "there was some delay in sounding the code blue alarm"; and

(vii) the evidence of the second respondent with which the first respondent had agreed that the hospital had to answer for the delay in transferring the first appellant from the ward to the OT for an immediate CS for the purpose of saving the first appellant and the second appellant.

[85] It is true that the trial judge did not address the issue of direct negligence of the hospital specifically in her judgment. This was noted by the Court of Appeal. However, as pointed out by the Court of Appeal, the trial judge examined the conduct of the first and second respondents and found them not negligent and so not liable. In her decision, the trial judge had painstakingly analysed the evidence of facts as to every action taken by the nurses and the doctors including the first and second respondents, as specialists in attending to the appellants.

[86] On our part, we have taken the complaints specifically. First, on the failure of the hospital to comply with reg. 20(4)(a) of the Private Hospitals Regulations 1973. Regulation 20(4)(a) states that there must be two nurses that is one registered nurse and one registered assistant nurse. DW11's evidence clearly shows that there would be three or four nurses on duty in one shift. Even the appellants' witness (PW2) states that "I went to the nurse station and called nurse. Two nurses came, they check on her blood pressure". Thus, we found no real evidence that the hospital had failed to comply with reg. 20(4)(a).

[87] On the issue of monitoring the appellants, we found that the nursing staff had monitored the first appellant regularly whilst she was under their care. The evidence clearly showed that the first appellant was examined at 6.30am prior to her admission to the hospital. A vaginal examination was performed by the nurse. The nurse had also proceeded to conduct a CTG on the first appellant. The CTG recordings show that the first appellant's condition was normal. At 9.50am the first appellant was seen by the first respondent who had instructed the nurse to take the first appellant to the maternity ward. At 10.30am the nurse had examined the first appellant who had complained of pain and vomiting. After examining the first appellant, the nurse duly informed the first respondent of the first appellant's condition. The nurse was instructed by the first respondent to insert an IV drip and to give maxalon and bricanyl. The nurse complied with the instructions.

[88] Further, at 10.50am the nurse examined the first appellant again. The first appellant had complained of pain and after examining the first appellant, the nurse informed the first respondent of the first appellant's complaint. At 10.55am she proceeded to check the first appellant's blood pressure. At that time, the first respondent was at the ward. In her note for the examination done at 10.55am she stated as follows "seen by Dr Maris. Noted BP can't found and patient collapsed". The nurse then proceeded to call the operator to sound the "code blue" alarm as instructed by the first respondent.

[89] It is clear from the evidence that the first appellant was regularly monitored while she was under the care of the hospital and all her complaints were conveyed to the first respondent. The nurses had also complied with the instructions given to them by the first respondent in the management of the first appellant.

[90] We also find that there was no delay in moving the first appellant to the OT for CS in the circumstance of the case. In fact, there was no evidence to show that the time taken to move the first appellant from the maternity ward to the OT was too long. The CS was performed within 30 minutes which is acceptable and within the recognised time frame. The evidence of the first respondent was that the first appellant's blood pressure was unrecorded at 11am and the baby was delivered at 11.25am.

[91] We find that the trial judge, as well as the Court of Appeal, had analysed all the above complaints by the appellants. There were concurrent findings of facts. We are unable to form a conclusion on the facts different from the conclusion reached by the courts below. We do not find the conclusion by the courts below to be so unreasonable that no reasonable tribunal would have come to that same conclusion.

[92] It was argued by learned counsel for the appellants that the findings of fact made and the opinions on matters outside the realm of ordinary human knowledge formed by the courts below were against the weight of evidence and not in accordance with law. With respect, we disagree. Insofar as the findings of fact of the High Court and the Court of Appeal are concerned, on the contrary, we find that the overwhelming weight of evidence was in fact against the appellants' contentions and allegations.

[93] As can be discerned from the trial judge's grounds of judgment, each and every contention which was canvassed was critically examined by the trial judge based on available evidence. In coming to her conclusion on all the appellants' allegations, the trial judge was at pains to point to and support her conclusion by reference to the evidence led, contemporaneous documentary evidence and oral evidence. We therefore find that the appellants' contention is without merit.

Conclusion

[94] Thus, it is our judgment that in respect of the standard of care in medical negligence cases, a distinction must be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other. This is because diagnosis and treatment are purely in the realm of medicine and that in the field of medicine, there are genuine differences of professional opinion in respect of diagnosis and treatment. Although as a discipline, medicine involves specific knowledge, its practice, however, often does not admit to scientific precision. It is not always the case that there is a definite answer one way or the other. In fact, medical experts do genuinely and frequently differ in opinion on diagnosis and treatment.

[95] Given the fact that there are genuine differences in opinion in diagnosis and treatment, it is therefore not a matter that the court can, or is, equipped to resolve. It is in this context that the *Bolam* test makes good sense. It requires the court to accept, not just the views of medical experts *simpliciter*, but the views of a responsible body of men skilled in that particular discipline. It removes from the courts the responsibility of resolving a dispute that is not equipped to resolve.

[96] On the other hand, different consideration ought to apply to the duty to advise of risks as opposed to diagnosis and treatment. That duty is said to be noted in the right of self-determination. As decided by the Australian High Court in *Rogers v. Whitaker* and followed by this court in *Foo Fio Na*, it is now the courts' (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment. The courts would no longer look to what a body of respectable members of the medical profession would do as the yardstick to govern the standard of care expected in respect of the duty to advise.

[97] Based on the foregoing, we will answer question 1 in the following manner. The test propounded by the Australian case in *Rogers v. Whitaker* and followed by this court in *Foo Fio Na* in regard to standard of care in medical negligence is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the *Bolam* test still applies, subject to qualifications as decided by the House of Lords in *Bolitho.*

[98] In light of the above findings, there is no necessity to answer question 2. We will answer question 2 in another appeal where the same question had been posed before this court.

[99] Based on the law that we have discussed, and the concurrent findings of facts as found by the courts below, and for the reasons given, we dismiss the appellants' appeal.